Costs are to be reflected in facility rates beginning July 1 1991, so that the nine months of incremental cost from April 1, 1991 to December 1991 will be reflected in the six month rate period July to December 1991. Total incremental costs were converted to a per diem add-on to be included in a facility's rate by dividing total incremental costs by available beds, and adjusting to days by dividing by 365. The calculation is as follows:

$17,041,640 / 105,000 / 365 = .45 add-on

This statewide add-on will be adjusted for each facility to reflect regional differences in RN salary levels for calendar year 1987. Such regional adjustments are currently used in the determination of the direct and indirect components of facility rates. For 1992 and forward, the incremental cost add-on will be increased by the appropriate trend factor.[6]

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[6]Trend factors are computed in accordance with Section 86-2.12.

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Description of Methodologies for the Physical, Mental, and Psychosocial Well Being Requirement

The State of New York reimbursement rates match payment with intensity of care, thus providing facilities with adequate reimbursement for patients requiring more intensive supportive, medical or rehabilitative care. The RUG II patient classification system classifies each patient into one of sixteen patient categories which are each different in terms of clinical characteristics and are statistically different in terms of costs of care.

The system uses a hierarchy of patient types and secondary subgroup format based on Activities of Daily Living (ADL) function levels. The five hierarchical groups, from the highest to lowest resource consumption, are as follows:

1. Special Care
2. Rehabilitation
3. Clinically Complex
4. Severe Behavioral Problems
5. Reduced Physical Functions

Each of the above clinical groups is further divided by the ADL index score into subgroups. The ADL index is comprised of three ADL variables, eating, toileting, and transfer, which were determined to be the key predictors of resource consumption within each clinical group. For each of the sixteen patient classification categories, a relative resource "weight" representing the resource consumption of patients in that category relative to the average patient, is used to adjust the direct component of the payment rate.

The RUGS system thus allows a more precise and equitable means of directing available fiscal resources to nursing homes that care for residents with the heaviest care needs. By recognizing the resources required to provide more intensive rehabilitative and support services, the reimbursement methodology encourages nursing homes to establish restorative care programs. This can result in more active intervention for eligible patients, and earlier improvement and discharge.

October 1, 1992

For rates effective January 1, 1992 and thereafter, the per diem add-on described herein will be increased by a trend factor as defined in Section 86-2.12.

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Description of the specific methodology for determining the adjustment - Bloodborne Pathogens

Hepatitis B Vaccination:

Beginning January 1, 1993 and thereafter, provider rates contain a facility-specific adjustment to reimburse the cost of the Hepatitis B vaccine administered to employees. Provider-specific adjustments are based upon each facility's actual costs recognized up to a maximum cost for the vaccine. The facility specific adjustment will be determined using costs reported by the providers two years prior to the start of the rate year. The maximum cost for the vaccine that is recognized when setting the facility specific adjustment is $128.50 for a three vial series per employee.

Gloves:

For rates effective on April 1, 1994 for the 1994 calendar year and each calendar year thereafter, an $.18 per diem adjustment will be included in provider's rates for the incremental cost of gloves.

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Attachment 4.19-D
Part I

86-2.11 - Adjustments To Direct Component Of The Rate:

(a) Payments for 1986 and subsequent rate years for the Direct Component of the rate as defined in subdivision (c) of section 2.10 of this Subpart shall be adjusted periodically as described in this section to reflect changes in the case mix of facilities.

(b) Facilities shall report to the department changes in patient case mix follows:

(1) Full Reassessments: Facilities shall, on a schedule to be established by the department, assess all their patients semi-annually and submit patient review instruments pursuant to section 86-2.30 of this Subpart. The department shall consider, in developing such schedule, that for each of the six months in a semi-annual period, there would be submitted approximately 1/6 of the assessments for all patients in the state.

(2) Assessment of patients admitted since the last assessment period: Three months from the date facilities are scheduled to perform full reassessments, facilities shall assess patients admitted and still residing in the facility since the last full assessment period. Patient review instruments for such patients shall be submitted pursuant to section 86-2.30 of this Subpart on a schedule to be established by the department. The department shall consider, in developing such schedule that for each six months in a semi-annual period, there would be submitted approximately 1/6 of the assessments of such new admissions.

86-4
supersedes
82-30

Approval Date JUL. 29 1987 Effective Date JAN. 1 1986

(3) Notification to department of patients discharged since last assessment period: Facilities shall notify the department of any patients assessed during the previous full reassessment period as described in paragraph one of this subdivision and since discharged concurrent with the submissions required by paragraph (2) of this subdivision for patients admitted since the last assessment period.

(c) Payment Rates for the Direct Component of the rate as defined in subdivision (c) of section 86-2.10 of this Subpart shall be adjusted, on a facility specific basis for changes in patient case mix retroactive to the beginning date of the month in which the assessment of patients was scheduled by the department and performed by the facility.

(d) Adjusted payment rates shall be determined by recalculating a facility's number of patients in each patient classification group as a result of the submissions in accordance with this section and such results shall be used in the calculation of the facility specific direct adjusted payment price erp day pursuant to paragraph four of subdivision (c) of section 86-2.10 of this Subpart.

(e) Trending: Payment rates for the operating component of the rate as defined in paragraph (2) of subdivision (b) of section 86-2.10 of this Subpart may be adjusted for changes in the trend factors originally promulgated by the department in accordance with section 86-2.12 of this Subpart.

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86-2.12 Adjustment to basic rate
Section (a) and (b) reserved;
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86-2.12

(a)RESERVED

(b)RESERVED

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(c) Beginning April 1, 1991, the commissioner, in accordance with the methodology developed pursuant to subdivisions (d), (e) and (f) of this section, shall establish trend factors for residential health care facilities to project allowable cost increases for the effects of inflation during the effective period of the reimbursement rate. The allowable basic rate prior to the addition of capital costs and depreciation and interest related to movable equipment shall be trended, beginning on April 1, 1991, to the applicable rate year by the trend factors developed in accordance with subdivisions (d) through (f) of this section.

(d) The methodology for developing the trend factors shall be established by a panel of four independent consultants with expertise in health economics appointed by the commissioner.

(e) The methodology for developing the trend factors shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for nonsupervisory employees.

(f)(1) On or about September first of each year, the consultants shall provide to the commissioner and the state hospital review and planning council, the methodology to be used to determine the trend factors for the rate period, commencing on the next January first. The commissioner shall monitor the actual price movements during these periods of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants and shall implement the recommendations of the consultants for one prospective interim annual adjustment to the initial trend factors to reflect such price movements and to be effective on January first, one year after the initial trend factors were established and one prospective final annual adjustment to the revised trend factors to reflect such price movements and to be effective on January first, two years after the initial trend factors were established.

(2) Notwithstanding the dates specified in paragraph (1), the consultants shall provide as soon as possible to the commissioner and the state hospital review and planning council, the methodology to be used to determine the trend factors for the rate period April 1, 1991 to December 31, 1991. One prospective interim annual adjustment for this rate period shall be made on January 1, 1992 and one prospective final annual adjustment for this rate period shall be made January 1, 1993.

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(g) Effective July 1, 1994, payment rates for the 1994 rate setting cycle will be calculated using the proxy data described in this section that is available through the third quarter of 1993. Proxy data which becomes available subsequent to the third quarter of 1993 will not be considered in setting or adjusting 1994 payment rates.